CERTIFICATE OF MEDICAL NECESSITY

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 524 (6-2006)

Clear Fields

CPAP/BiPAP

SECTION A - Certification Type/Date:

Date	☐ Initial ☐ Revised
Name	Patient ID

SECTION B - To be completed by the physician

1. Date of Polysomnogram: (Polysomnogram required for all CPAP requests)	
2. If request is for BiPAP, explanation of the inability to tolerate CPAP:	
3. Results of Sleep Study	Obstructive Apneas:
AHI:	Lowest Oxygen Saturation: %
Sleep Time: Hours	Total Apneas:
4. If prescribed for central sleep apnea, fill out this section.	
Central apneas/hr: Hours	Longest central apnea: Hours

SECTION C - Narrative Description

Narrative description of **ALL** items, accessories and options etc.: (if additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included in the attached document).

SECTION D Physician Signature/Date

Signature	Date	(Signature and Date Stamps are not acceptable)